

HEAD START & EARLY HEAD START ENROLLMENT APPLICATION

THE CHILD'S INFORMATION

☐ EHS ☐ HS ☐ NVP/LIFT

Child's legal name	First	Middle Initial	Last	
Age by December 2nd		Child's Place of Birth (City, State)	Child's DOB (mm/dd/yyyy)	Sex
Child's Race Pacific islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Biracial/ Multi <input type="checkbox"/> Hispanic <input type="checkbox"/> Nat. Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Other _____		Child's Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Asian <input type="checkbox"/> Native/Central/South American & Mexican <input type="checkbox"/> Other _____		Secondary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Asian <input type="checkbox"/> Other _____

THE CHILD'S HOUSEHOLD FAMILY INFORMATION

1 Primary adult name		Ethnicity	Primary Language if different from child		Secondary Language if Different from child	
2 Secondary Parent (if any)		Ethnicity	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Parental Status: <input type="checkbox"/> One parent <input type="checkbox"/> Two parent	
Residential Address			Mailing Address (if different from Residential Address)			
City	State CA	Zip Code	City	State	Zip Code	
Primary Phone Number (including area code)			Other Phone (including area code)			
Total in Family	Total # of Children	Ages 0 – 3:	Ages 4-5	Current Housing: <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____ Date you moved in _____ Previous Housing: <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____		
E-mail Address:						

ELIGIBILITY INFORMATION

Does Family Receive SSI/TANF/Cal works?	Check one if applicable: <input type="checkbox"/> Medi-cal <input type="checkbox"/> IEHP <input type="checkbox"/> Healthy Families <input type="checkbox"/> Emergency <input type="checkbox"/> Other _____		Does Family Have Medical Insurance?		
Does Family Receive Food Stamps?	If yes Food Stamp #	Does Family Receive WIC?	Does Child Have Dental Insurance?		
How did you hear about us? <input type="checkbox"/> Community Event <input type="checkbox"/> Flyer/Poster <input type="checkbox"/> School District <input type="checkbox"/> Community Partner Referral <input type="checkbox"/> Former Parent <input type="checkbox"/> Other Head Start <input type="checkbox"/> State Preschool <input type="checkbox"/> Facebook <input type="checkbox"/> Local Community Agency Referral <input type="checkbox"/> Public Advertisement <input type="checkbox"/> Family Friend <input type="checkbox"/> Mailings <input type="checkbox"/> Public Service Announcements (TV/Radio) <input type="checkbox"/> Other _____					
PARENT AND/OR GUARDIAN			INCOME SOURCE		
1			<input type="checkbox"/> Employment <input type="checkbox"/> Disability <input type="checkbox"/> TANF <input type="checkbox"/> SSI <input type="checkbox"/> Unemployment <input type="checkbox"/> Other _____		
2			<input type="checkbox"/> Employment <input type="checkbox"/> Disability <input type="checkbox"/> TANF <input type="checkbox"/> SSI <input type="checkbox"/> Unemployment <input type="checkbox"/> Other _____		

PRENATAL INFORMATION

☐ Pregnant before Enrollment ☐ First Pregnancy Expected delivery date: _____

ADULT HOUSEHOLD FAMILY MEMBER INFORMATION

(Enter Primary Adult First) First & Last Name	Date of Birth	How Related to Applicant	Sex	Education Level	Employment Status	Going to school/training
1						
2						
3						
4						

First & Last Name of Children in Home	Date of Birth	Sex	How Related to Applicant	Notes
1			Applied Child	
2				
3				
4				
5				
6				
7				

TRANSPORTATION INFORMATION

Type of Transportation? Check one. ☐Car ☐Bus ☐Walk ☐Other

Is Head Start Bus needed? If needed, why?

Children with special needs may receive priority for Head Start enrollment. Your disclosure of this information is strictly Voluntary.

1. Does your child have a disability? _____ (If no, please go to question #6)
2. Type of special need or disability _____
3. Has the disability been professionally diagnosed? (If yes, at what age _____? By whom? _____)
4. Does the child have an IEP? _____
5. Is the child receiving special services for the disability? _____
6. In your opinion, does your child have a special need that has not yet been diagnosed?
If yes, please explain: _____

Certification: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature:

Date:

TO BE COMPLETED BY STAFF

School Year:	Center Name:	Participation Year: 1 st 2 nd 3 rd	Start Date:
Acceptance Status: <input type="checkbox"/> Accept <input type="checkbox"/> Denied	Program Type		
Category of Eligibility <input type="checkbox"/> income <input type="checkbox"/> over income <input type="checkbox"/> public assistance <input type="checkbox"/> SSI <input type="checkbox"/> Homeless <input type="checkbox"/> Foster Care			
Child Eligible Next Year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sibling Eligible Next Year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family ID: (COPA)	
Income Verified By <input type="checkbox"/> Check Stub <input type="checkbox"/> W2 <input type="checkbox"/> Written Statement from Employer <input type="checkbox"/> TANF <input type="checkbox"/> Income Tax 1040 <input type="checkbox"/> Unemployment <input type="checkbox"/> SSI Documentation <input type="checkbox"/> Document of no income <input type="checkbox"/> Foster Care Reimbursement <input type="checkbox"/> Other (Please Explain)			
Total Annual Income: \$			
Birth Verified By Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Medi-cal Card <input type="checkbox"/> Other <input type="checkbox"/>			
Verifying Staff member Signature:		Print Name	Date: